STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020657

[redacted]

[redacted]

On October 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 15, 2017 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

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If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020657

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine you were not eligible for retroactive Medicaid coverage for the month of May 2017?

Procedural History

On July 11, 2017, NYSOH received an updated application submitted on your behalf requesting retroactive coverage for the month of June 2017.

On July 12, 2017, NYSOH issued an eligibility determination notice stating that to determine your eligibility for retroactive Medicaid coverage for the month of June 2017 you needed to submit proof of your income for that month by July 26, 2017.

On July 12, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On July 13, 2017, NYSOH issued an eligibility determination stating you were eligible to receive advance premium tax credits (APTC) of up to $315.00 monthly, effective August 1, 2017.

Also on July 13, 2017, NYSOH issued an enrollment notice confirming you were enrolled in a qualified health plan with APTC applied, effective August 1, 2017.

Additionally, on July 13, 2017, NYSOH issued a notice stating you were eligible for retroactive Medicaid coverage for the month of June 2017, because your

monthly household income of $0.00 was under the allowable monthly income limit for Medicaid.

On July 14, 2017, NYSOH received another updated application for financial assistance with health insurance submitted on your behalf requesting retroactive coverage for the month of May 2017.

On July 15, 2017, NYSOH issued an eligibility determination stating you were eligible to receive advance premium tax credits of up to $315.00 monthly, effective August 1, 2017.

Also on July 15, 2017, NYSOH issued a notice stating you were not eligible for retroactive coverage for the month of May 2017, because the program you were eligible for could not pay for any care you received in the past.

On July 19, 2017, you spoke to NYSOH's Account Review Unit and appeal the July 15, 2017 eligibility determination.

On October 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing, and held open until October 26, 2017 to allow you to submit supporting documentation.

No additional documentation was received by that deadline, and the record closed thereafter.

Findings of Fact

A review of the record supports the following findings of fact:

1) You were enrolled in catastrophic health plan, effective January 1, 2017.

2) On May 27, 2017, you updated your application, decreasing your attested annual income, and indicating you lost your job on March 31, 2017.

3) NYSOH requested income documentation to verify the information in your application and you were disenrolled from your catastrophic health plan, effective June 30, 2017.

4) On May 27, 2017, you uploaded a single weekly paystub with a check date of April 7, 2017 for a pay period ending on March 31, 2017 [redacted] This document was invalidated by NYSOH on May 30, 2017.

5) On July 11, 2017, you updated your application, requesting retroactive coverage for the month of June 2017. That application indicated you had no income in the month of June 2017.

6) NYSOH requested income documentation to verify your income for the month of June 2017.

7) On July 11, 2017, you uploaded a Record of [redacted] from the [redacted] indicating you had a claim for [redacted] beginning June 19, 2017 [redacted] with the first IUB payment issued on July 2, 2017.

8) According to your account, NYSOH accepted the income documents submitted on July 11, 2017 as proof that you had no income in the month of June 2017 and you were determined eligible for retroactive Medicaid coverage for that month.

9) You were determined eligible to receive APTC, effective August 1, 2017, and you enrolled in a qualified health plan.

10) You submitted another updated application on July 14, 2017. That application requested retroactive coverage for the month of May 2017 indicating that you had no income in that month.

11) According to your account, NYSOH denied your request for retroactive Medicaid coverage for the month of May 2017 on the grounds “the program you were eligible for [could not] pay for any care you received in the past.”

12) You testified you are only appealing the denial of retroactive Medicaid coverage for the month of May 2017. You testified you are not appealing your current eligibility.

13) You testified that you had no income in the month of May 2017. You testified that your prior employment ended on March 31, 2017 and the paystub for the April 7, 2017 paycheck that you previously submitted was the last paycheck you received from that job. You testified that you did not begin receiving [redacted] until June 2017.

14) At the hearing, you were directed to submit a letter from your former employer confirming the last day of your employment. As of the date of this decision, NYSOH has received no such documentation.

15) The July 14, 2017 application indicated you would file your 2017 tax return with a tax filing status of single and you would claim no dependents. You testified that information was accurate.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of the relevant applications, that was the 2017 FPL, which is $12,060.00.00 for a one-person household (82 Federal Register 8831).

Retroactive Medicaid

The Department of Health must make Medicaid coverage available retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time she received the services if she had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Legal Analysis

The issue under review is whether NYSOH properly determined you were not eligible for retroactive Medicaid coverage for May 2017.

On July 14, 2017, you submitted an updated application requesting retroactive coverage for the month of May 2017. NYSOH denied this requesting stating, in the July 15, 2017 notice, "the program you were eligible for [could not] pay for

any care you received in the past." You appealed that determination insofar as you were not eligible for retroactive Medicaid coverage for the month of May 2017.

Pursuant to the regulations, when an individual applies for Medicaid through NYSOH, his or her eligibility for retroactive Medicaid depends on the date of the application. To this end, it does not matter whether that initial application resulted in Medicaid going forward. Instead, an individual who has filed an initial application for Medicaid through NYSOH has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Therefore, the basis for the denial of retroactive coverage for the month of May 2017, as stated in the July 15, 2017 notice, is not supported by the regulations. However, notwithstanding, there is insufficient evidence in the record to find you were eligible for retroactive Medicaid coverage for the month of May 2017.

You testified, and your July 15, 2017 application indicates, that you had no income in the month of May 2017. Although you testified your last day of employment was March 31, 2017 and submitted a paystub for that pay period, you were directed to submit a letter from your former employer confirming the last date of your employment. You failed to submit any such documentation.

Furthermore, evidence submitted establishes that you did not file a claim with the [redacted] until June 19, 2017. Given the sizable gap between your attested last day of employment, March 31, 2017, and the June 19, 2017 filing of your claim for UIB, it is concluded that your uncorroborated testimony that you had no income for the month of May 2017 is unreliable, especially because you were provided an opportunity to submit corroborating evidence but failed to do so.

Since, there is insufficient evidence of your income for the month of May 2017, the July 15, 2017 notice, to the extent it denied your request for retroactive Medicaid coverage for the month of May 2017, is AFFIRMED; the notice is MODIFIED only to reflect that this denial is based on insufficient evidence to show that you qualify for this benefit financially.

Decision

The July 15, 2017 notice denying your request for retroactive Medicaid coverage for the month of May 2017 is AFFIRMED; the notice is MODIFIED only to reflect that this denial is based on insufficient evidence to show that you qualify for this benefit financially.

Effective Date of this Decision: November 14, 2017

How this Decision Affects Your Eligibility

There is insufficient evidence in the record to determine you eligible for retroactive Medicaid coverage for the month of May 2017.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The July 15, 2017 notice denying your request for retroactive Medicaid coverage for the month of May 2017 is AFFIRMED; the notice is MODIFIED only to reflect that this denial is based on insufficient evidence to show that you qualify for this benefit financially.

There is insufficient evidence in the record to determine you eligible for retroactive Medicaid coverage for the month of May 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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